North East
North Cumbria
Health & Care
Partnership

NHS
North East and
North Cumbria

High quality and safe care for all...

Quality Strategy
2024 - 2029

Contents

1. Introduction

High quality and safe care for our communities

Introduction

All of us care deeply about ensuring our patients are protected from avoidable harm. By working together across our region, we have an opportunity to do even more to make care safer and set the highest ambition for quality and safety standards for our communities.

Our region-wide quality strategy is key to this.

Our strategy supports and builds on the work already underway across health and care organisations in the North East and North Cumbria to develop a positive culture of safety, openness and learning. While individual organisations have actions in place, we strongly believe there is added value in having common standards applied consistently across our region.

Recognising this, our strategy sets out standards across key overarching themes of culture and climate, positive experiences, patient safety, clinical and multi-professional leadership and clinical effectiveness.

Understanding and listening to what is important to our communities, services users and colleagues when it comes to safe and high-quality care has also played a crucial part in the development of this strategy. We would like to thank those who took the time to share their views – many of which are reflected in this document.

The delivery of this strategy is also supported by the creation of our learning and improvement community, called Boost. This supports our ambition to be 'the best at getting better' with learning and improvement at the heart of everything we do and is about mobilising our teams across the region to support learning at every opportunity.

Being the largest ICB we also have a unique opportunity to work at scale to tackle the common causes and risks of unsafe care. With more than three million people in our region we have a huge amount of data with which to identify risks and problem solve. Alongside drawing on the best international evidence puts us in a strong position to innovate and make patients care as safe as it can be.

Our strategy also sets out how we will be establishing our North East and North Cumbria Patient Safety Centre to support the transformative changes we want to see and improve the safety and experience of care.

Our challenge now is to ensure that we now make the ambitions in this strategy a reality for the communities we serve - something we can only do by working together, and by listening and understanding to what matter to our communities, service users and staff.

Professor Sir Liam Donaldson
Chair
North East and North Cumbria Integrated Care Board

David Purdue
Executive chief nurse and people officer, deputy chief executive officer
North East and North Cumbria Integrated Care Board

2. Our ICB vision

Our ICB vision

In our strategy, Better health and wellbeing for all, our vision for North East and North Cumbria (NENC) is better, fairer, health and wellbeing for everyone. This inclusive vision captures the need to improve health and broader wellbeing for everyone across the North East and North Cumbria.

Our aim is to be 'the best at getting better.' We have already created a learning and improvement community, called Boost, to mobilise people from across the region. We intend to build our learning system as a culture, a community, and a collection of assets that support learning at every opportunity.

Our goals are:

To achieve longer, healthier lives for everyone

Fairer health outcomes for all

Improving health and care services

The best start in life for our children and young people

Within our strategy, we identify that health inequalities arise because of variations in the conditions in which we are born, grow, live, work, and age, meaning that we do not all have the same opportunities to be healthy. One key measure of health inequalities is inequalities in life expectancy, the difference in how long groups of people live on average. Mortality rates from the Covid-19 pandemic have been considerably higher in the more deprived areas, deepening health inequalities.

By April 2022, the cumulative death rates since the start of the pandemic in people aged under 75, were 3.5 times higher in the most deprived areas compared to the least deprived across the North East and North Cumbria. Nationally, the pandemic had a disproportionate impact on people from some ethnic minority groups, in terms of higher mortality rates.

There is also growing evidence that those communities impacted by health inequalities and social determinants of health (such as housing, education, employment, etc), as well as people with protected characteristics, may be disproportionately affected by poorer health outcomes, harm and premature deaths.

Examples of increased patient harm include:

- Themes from the Learning Disabilities Mortality Review programme (LeDeR) show that people with a learning disability experience more respiratory problems and there is an under recognition of early deterioration of the person's condition and recognition of sepsis.

- Studies have found that people with learning disabilities are almost four times as likely to develop sepsis.
- People from the most socio-economically deprived groups were nearly twice (80%) as likely to die from sepsis within 30 days, than those in the least deprived socio-economic groups.
- People in inclusion health groups tend to have poor experiences of healthcare services. For example, these are people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery. These negative experiences can lead to people avoiding future contact with health and care services and being less likely to receive healthcare despite having high healthcare needs. This can result in significantly poorer health outcomes and earlier death among people in inclusion health groups compared with the general population. For example:
  - » A&E attendances are 6-8 times higher for people experiencing homelessness and 28 times higher for people who experience both homelessness, rough sleeping, and alcohol dependency.
  - » The children of parents in inclusion health groups are more likely to have poor health across their life course because of their disadvantaged start in life.
  - » Gypsy, Roma and Traveller communities report difficulties in registering with a GP because of a lack of cultural awareness and a perception that they will be 'expensive patients.' GPs may also be reluctant to visit sites.
  - » Standardised all-cause mortality data illustrates that the relative mortality of people in inclusion health groups far exceeds that of people from the most deprived communities of England; the inequality of outcomes among inclusion groups is extreme.
  - » Drug-related deaths in deprived areas across the North of England are much higher than in other parts of the country, with opiates accounting for more than half of these.
- The Resuscitation Council (2024) in their 'Every second counts: Tackling inequalities in resuscitation' report found several health inequalities impacted on the survival outcomes in cardiac arrests including:
  - » Women are less likely to receive cardiopulmonary resuscitation (CPR) and have lower survival rates at each successive stage of care.
  - » Evidence confirms that out-of-hospital cardiac arrest disproportionately affects people from certain ethnic minority backgrounds, research has shown this is linked to higher rates of cardiovascular disease.
  - » Socio-economic status is linked to a higher risk of cardiac arrest; poverty, poor diet, higher incidence of smoking and higher rates of mental health illness are associated with higher incidence of cardiac arrest.

- The Care Quality Commission (CQC) identified in their State of Care 2022/23 report that there were ongoing inequalities for people from ethnic minority backgrounds across several areas, including maternal and neonatal health care and mental health care. For example:
  - » Rates of detention for people from Black or Black British heritage groups were more than four times those of people from the White heritage group.
  - » Midwives from ethnic minority groups said that care for people using maternity services was affected by racial stereotypes and a lack of cultural awareness among staff.
  - » Midwives from ethnic minority groups described a 'normalised' culture where staff tolerated discrimination from colleagues and said they were less likely to be represented in leadership and managerial roles.
  - » Patients from ethnic minority groups, who have a long-term condition, were more than 2.5 times more likely to say that staff in the emergency department talked as if they were not there, compared with patients in White heritage groups who did not have a long-term condition.
  - » People from ethnic minority groups who have long-term conditions felt they were talked down to about their treatment and not treated as individuals. They also said a lack of cultural competency was a barrier to receiving good quality care.
- The National Child Mortality Database's thematic report on child mortality and social deprivation identified that there was a clear association between the risk of death and level of deprivation for children who died in England between April 2019 and March 2020. On average there was a relative 10% increase in risk of death between each decile of increasing deprivation. Over a fifth of all child deaths might be avoided if children living in the most deprived areas had the same mortality risk as those living in the least deprived. This translates to over 700 fewer children dying per year. (NCMD 2021).

Within our Quality Strategy, we have used 'I' and 'we' statements as high-level strategic intentions to describe the level of care our people and communities have the right to expect; and how we can all contribute to delivering high-quality care.

We define these as:

- 'I' statements help people understand what a good experience of care looks and feels like, and the statements reflect what people say matters to them.
- 'We' statements highlight the collective efforts of individuals, teams and services, organisations, and the system, in fostering a culture of unity, mutual respect, and shared responsibility in delivering high-quality care.

Our region-wide Quality Strategy will support and build a positive culture of safety, openness, and learning across health and care in our region. We have a real opportunity to set the highest ambition for quality and safety standards in our region.

Professor Ted Baker, Chair of Health Services Safety Investigation Body (HSSIB) and formerly the CQC's Chief Inspector of Hospitals, stated in the foreword to Patient Safety- Emerging Applications of Safety Science book that:

"There have been numerous major reports on safety problems in health services over recent years and they all have a recurrent theme; we have not listened to patients and those close to them nearly well enough. Patients' voices are vital, not just because they may have been harmed but because they have experienced safety from a different perspective, they have seen how healthcare is actually provided, not how we often imagine it is provided. If we are to improve safety, we must understand how it is experienced by patients. We must draw on their expertise and understanding, we must listen to the diversity of their views."

Viewing health inequalities and patient experience through the lens of patient safety gives us a unique opportunity to take meaningful action to reduce the risks of harm and improve the quality of care people receive across our region. We will do this by working with people and partner organisations across the Integrated Care System (ICS) to support the delivery of our quality strategy.

Quality Management System

Underpinning our Quality Strategy will be our Quality Management System (QMS). This includes several supporting strategies, policies and frameworks that are part of our quality oversight, monitoring, and improvement work across the ICB and ICS. This will complement our Safety Management System and provide the practical system and processes to support the delivery of our Quality Strategy.

The QMS will include:

- **Quality planning** - this is about understanding the needs of our people and diverse communities and designing quality and safety strategies, priorities, structures, and processes. This is to enable us, as an ICS, to meet the needs of our people and diverse communities.
- **Quality control** - is the set of measures and management processes used to monitor quality and safety. This process can monitor and compare actual performance against goals and targets. This will help to identify gaps in quality and safety, and support services, directorates, and organisations to put in place actions to mitigate risks to quality.

- **Quality improvement** - is a systematic approach to improve quality, safety and performance by adopting a learning approach to tackle our biggest problems and build a thriving learning and improvement community. Improvement will become part of our everyday processes, driven by people's experiences and delivered by skilled and experienced staff. We will develop our North East and North Cumbria improvement approach to reflect this.
- **Quality assurance** - is the system and processes used across the ICB and ICS to monitor, provide oversight and assurance of quality and safety across the health and care system. The quality assurance system will be based on information and evidence to demonstrate that the requirements (statutory, legislative, regulatory, or contractual) for quality and safety are being met. This is in line with our duties under the Health and Care Act (2022) to secure continuous improvements in the quality of services and that outcomes are achieved from services within the ICS.

Healthcare Improvement Scotland (2022) in their 'Moving from Quality Improvement to Quality Management' document defined the difference between quality control (day-to-day management) and quality assurance (governance) as:

'Quality control and quality assurance have much in common. Each evaluates performance. Each compares performance to goals.

Each acts on the difference. However, they also differ from each other. Quality control has its primary purpose which is to maintain control. Performance is evaluated during operations, and performance is compared to goals during operations. The resulting information is received and used by the operating forces. Quality assurance's main purpose is to verify that control is maintained. Performance is evaluated after operations.'

Our quality actions and priorities

Working together across the health and care system, we will develop our strategic plans on how we will deliver our Quality Strategy over five years with clear actions, and outcomes. Each year we will publish our Quality Strategy actions and priorities. Throughout the year through our Quality Management System, we will monitor progress against plans to ensure we are making the difference to people's experiences and improve the quality and safety of care they receive.

We will base our system quality priorities on key quality and safety issues which have been identified from

- patient and public feedback and complaints
- thematic reviews of data (including performance)
- patient safety events, audits, reports and inquests
- child and adult safeguarding reviews
- wider national learning.

We will do this to ensure we focus on what matters to people and to ensure that we have a systematic approach to improvement, quality, and safety across our system.

Each year:

- We will set quality actions and priorities; each one will have a dedicated executive/director lead from within the health and care system to provide leadership and oversight of the improvement journey.
- Quality improvement activities will be driven by our patient safety centre. This will include learning events, shorter timescale quality improvement projects, and systemic-wide improvements we want to focus on.
- Timelines for large-scale system-wide quality priorities, will be determined for each priority. This will enable us to have wider impact working across organisational boundaries and our system.

Our Patient Safety Centre

The Patient Safety Strategy (NHS England 2019) describes the journey the NHS has taken about patient safety, by moving away from focusing on harms to focusing on safer systems. These are systems that provide safe and effective care (as intended and every time) by learning from what works well, not just when care does not go as planned. This also involves hearing the experiences of key stakeholders such as patients and staff, both of which will have a unique perspective on patient safety events. This means we need to empower people with the skills, confidence and mechanisms to improve safety.

The creation of the Integrated Care Board (ICB) has given us a unique opportunity to address patient safety at scale and make transformative and sustained improvements that have never been achieved before. Patient safety is a golden thread throughout our Quality Strategy so that

together we can make transformative changes to improve the safety and experience of care that people in the region receive.

Therefore, to support the delivery of our Quality Strategy we will establish our North East and North Cumbria Patient Safety Centre which will be a focal point to drive improvements. We will identify core functions with a clearly defined system role; we intend to launch our Patient Safety Centre in October 2024.

As part of our Patient Safety Centre, we will develop our own Safety Management System (SMS) that will align with the broad areas of activity that are identified as being foundational to managing and improving safety. The Safety Management System will be an integral part of our Quality Management System.

These are:

- **Safety policy** - the commitment to improve safety, clarity of responsibilities, and defining the way the ICB needs to be organised across the system to meet safety goals and priorities.
- **Safety risk management** - the identification of concerns, issues and risks, and the assessment and mitigation of risks across the system.
- **Safety assurance** - monitoring, measuring and oversight of safety performance, continuous improvement, and continuous evaluation of risk controls.
- **Safety promotion** - training, education, learning and communication to support a positive safety culture within all levels of the workforce, across organisations and communities within our system. This also includes the work we undertake with our people, communities, and stakeholders to address health inequalities and reduce avoidable harm.
- **Safety maturity** - this is the assessment and measurement of how far an organisation or system has developed and embedded its Safety Management System.

People will remain at the heart of all that we do both as an ICB and as an ICS. We are committed to being ambitious and courageous and will strive for excellence to improve the quality and safety of services.

3. Where it started, the national context

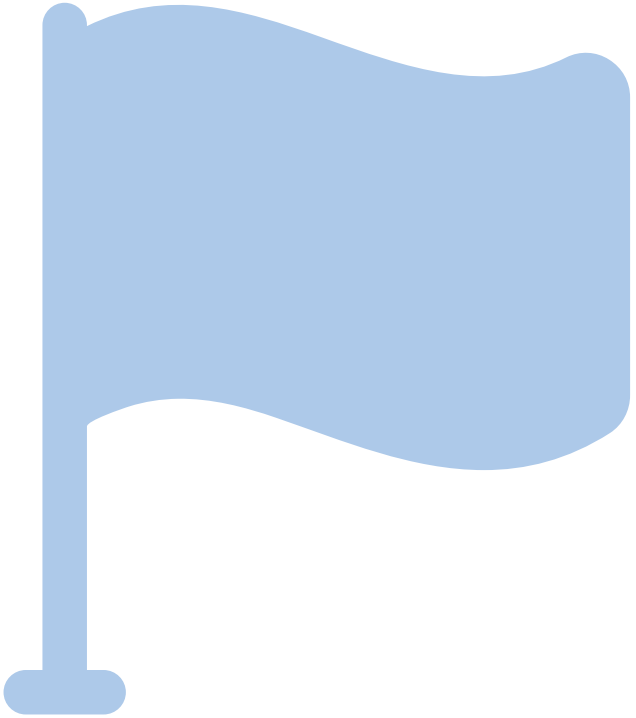
Where it all started, the national context

When developing our Quality Strategy, we considered national drivers, relevant publications, and documents, to help inform our strategy. These include:

- **The NHS Long Term Plan** (2019) sets out a 10-year programme that aims to improve health and care for local people of all ages, so that they can get the right care, in the right place, at the right time.
- **The NHS Long Term Plan** also made a renewed commitment to improve and widen access to care for children and adults needing mental health support; this included the development of the mental health implementation plan 2019/20-2023/24.
- NHS England's **Patient Safety Strategy** (2019) explains that patient safety is about maximising the things that go right and minimising the things that go wrong. It is integral to the NHS definition of quality in healthcare, alongside effectiveness and patient experience. They define a safety culture as an environment that is supported by continuous learning and improvement of safety risks, supportive, psychologically safe teamwork and enabling and empowering speaking up by all.
- In 2022, the **National Quality Board (NQB) published a shared commitment to quality**, in this guidance on a shared view of quality across health and care systems, which provides the foundation for system working around quality, championing the need to ensure that quality is a shared goal that requires us all to commit and act. Quality care is understood in the guidance according to the NQB Shared Commitment's definition, as care that is safe, effective, provides a personalised experience, is well-led and sustainably resourced. The NQB is also clear that quality care must be equitable, focused on reducing inequalities and addressing wider determinants.
- The NQB (2022) also published guidance on **Improving the experience of care**. The core ambition of the guidance being that improving people's experiences should be as important as improving clinical outcomes and safety, with a commitment to embedding this across services and pathways and within integrated care systems.
- The World Health Organisation (WHO) produced a **global safety action plan** 2021-2030 towards eliminating avoidable harm in health care. The plan provides a framework for action through seven strategic objectives, to enable strategic and coordinated approaches to patient safety.
- Following on from the patient safety strategy, NHS England produced a **Just culture guide**. Within this they use Professor Sir Norman Williams definition which is stated as, 'A just culture considers wider systemic issues when things go wrong, enabling professionals and those operating the system to learn without fear of retribution.'
- The Care Quality Commission's (CQC) **A new strategy for the changing world of health and social care** (2021), strengthens the commitment to deliver CQC's purpose: to ensure health and care services provide people with safe, effective, compassionate, high-quality care and to encourage those services to improve. The strategy has four themes which focuses on what's important to people and communities when accessing services, smarter regulation, safety through learning by regulating for stronger safety cultures across health and care and accelerating improvement to help improve the quality of care.

- In 2018, CQC published their report '**Opening the door to change'** which looked at NHS safety cultures and the need for transformation. Specifically, it found that although healthcare was by its nature 'high risk', the review found that due to increasing pressures within the NHS, this was not consistently reflected in its culture and practice. In contrast, other safety critical industries accept that their work is high risk, ensuring that this approach informs everything that they do. While it is recognised that healthcare is different, there is still much the NHS can learn from these high-risk industries to ensure risks are identified and managed proactively, with a greater understanding of team dynamics, situational awareness and human factors, and with safety protocols followed consistently.
- In 2024, Claire Cox, Helen Hughes and Jordan Nicholls published **Patient Safety- Emerging Applications of Safety Science** which highlighted the importance of safety science and patient safety as a discipline, which involves a framework of activities that creates cultures, processes, behaviours, technologies, and environments in healthcare that consistently and sustainably lower risks, and the occurrence of avoidable harms. A key feature of this is collecting data on patient safety events and using this data to improve our understanding, learn and find ways of working to reduce the risk of reoccurrence.
- In 2023 NHSE published a national framework for action on **Inclusion Health**. Inclusion health groups is an umbrella term used to describe people who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence, and complex trauma. This includes people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery. This framework supports services to plan, develop and improve health services to meet the needs of people in inclusion health groups.
- Healthcare Improvement Scotland (2022) in their **Moving from Quality Improvement to Quality Management** document which states that reliable delivery of high-quality care requires an organisational approach that goes beyond quality improvement to one which is inclusive of all the key components of quality management.
- **The Health and Care Act 2022** was introduced as a legislative framework to formalise the establishment of ICB's and detailed their specific responsibilities and duties. Within the act, ICB's have a duty to continually improve the quality of services, but also the duty to promote the involvement of patients, the duty to promote innovation and research, and the duty to promote integration.
- Specifically, **the act** obliges the ICB to secure continuous improvements in the quality of services and outcomes that are achieved from the provision of services with outcomes that show: -
  - The effectiveness of the services.
  - the safety of services.
  - The quality of the experience undergone by patients.
- Within The **NHS People Plan: We are the NHS** (2020) – action for us all, it focuses on how in the NHS, we all must continue to look after each other and foster a culture of inclusion and belonging, as well as action to grow our workforce, train our people, and work together differently to deliver patient care.

- The NHS Leadership academy produced **Our Leadership Way – The Heart, Head, and Hands of Leadership** compassionate, curious, and collaborative. Complementing the NHS People Promise, Our Leadership Way formalises the approach NHS leaders should take to develop this even further. It requires every leader, at whatever level across the NHS, to recognise, reflect and bring to life every day, six core principles. One way to conceive this is to think about the Heart, Head and Hands of leadership; the things we must consciously think about, the things we and others feel and the things we should do. In short, we should lead with compassion, curiosity, and collaboration.
- In 2022, NHS England published the **Patient Safety Incident Response Framework** (PSIRF) which sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents, for the purpose of learning and improving patient safety.
- NHS England's **Quality and Outcomes Framework** sets out the expectations for quality in general practice (GPs). It includes provision for quality improvement in line with the shared commitment to quality.
- **First Do No Harm**, the 2020 report by Baroness Cumberlege, highlights the harm to people from medicines and devices and urges the NHS to take a person-focussed approach to minimising these. Specifically, it states that the system is not good enough at spotting trends in practice and outcomes that give rise to safety concerns. Listening to patients is pivotal to that.



4. What people say high quality care means to them

What people say high quality care means to them

In order to understand what was important to our communities across the system we listened to the public, service users and colleagues. This is what they said high quality meant to them, and therefore what it means to us.

What our people and communities told us:

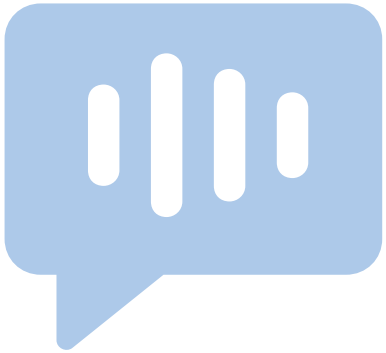
- Receiving healthcare that is proven to be the best, no matter where you live.
- Enabling people to live their best life no matter what their care needs are.
- Good care that makes you feel safe, looked after, and involved.
- The best quality care at the time when it's most needed.
- Providing our communities with the best resources, with highly trained professionals who can deliver the highest standards of care.
- It's an upmost priority to continue to improve and meet patient need.
- Evidence-based practice combined with a focus on patient needs.
- Being heard and listened to, feeling safe when receiving care, and having treatment options explained.
- Proactive not reactive treatment delivered with care and compassion.
- Easy access, timely investigations, treated as an equal and with respect for my choices.
- Excellent care, like you are looking after your own family, receiving the right treatment, at the right time, in the right place.
- Safe, kind, and compassionate care.
- Being listened to, with timely and appropriate treatment tailored to you.
- Accessible, fair, and equitable healthcare delivered by competent health professionals.

What providers and stakeholders told us:

- Confidence that everyone receives the highest level of care.
- High quality care means providing the best evidence-based health and social care services to our people who need them.
- Evidence-based appropriate care delivered in partnership with the recipient.
- High quality care is the provision of safe and effective care which is individualised and delivered with the patient experience at the heart.
- Quality is the fundamental barometer by which we make decisions, deliver services, and monitor the effectiveness of clinical services.
- High quality care means working together to develop a positive culture of openness, transparency, and shared learning across the system.
- Communication and respect between all system partners to enable the best quality care for all.
- To ensure we deliver our organisations quality aims and objectives, we need to collaborate across traditional boundaries to meet the health needs of the population as a whole. We have a system as well as an organisational responsibility.
- Collaboration to ensure care is provided in the most suitable place.
- Communication and respect between all system partners to enable the best quality care for all.

What staff told us:

- Patient safety primarily, then job satisfaction, knowing we are giving the best care we can.
- The best offer of care, provided by a highly trained workforce and within an acceptable time frame.
- Safe practice and equity of services no matter where you live.
- Delivering interventions that not only meet the medical need but take into account how this affects the patient's life and delivering real improvements for them.
- Safe, effective delivery of care, underpinned by evidence-based strategies and models of care.
- Timely, relevant, and responsive patient care.



5. Our overarching strategic themes


Culture and climate
Positive experiences
Patient safety
Quality Strategy
Clinical and multi-professional leadership
Clinical effectiveness

Culture and climate

"The most important single change in the NHS in response to this report would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end-to-end."

(Berwick Review into Patient Safety, 2013).

"To create cultures of high quality, continually improving and compassionate care we must understand the existing culture and put in place measures to achieve a culture that truly represents and reinforces those values of high-quality (safe, clinically effective, patient centred) care, continual improvement and compassion."

(Professor Michael West, The Kings Fund).

Our vision for culture across North East and North Cumbria

It has long been recognised that the culture of organisations or the health and care system shapes the values and behaviours of everyone in it, the quality of care it provides and its overall performance. Culture matters if we want to consistently deliver safe, high-quality care and continually improve. Despite many reports being written on the importance of safety cultures within the NHS, there is still much more to do to ensure that safety and high quality care are consistently delivered to reduce the risks of avoidable harm.

Robert Francis QC, in his 2013 report (The Francis Report – report of the Mid-Staffordshire NHS Foundation Trust public inquiry) on speaking up stated that: "There can also be various cultures within the same organisation. Different teams, different departments, and different hospital sites can all 'feel' different. A whistleblower interviewee described the contrast between teams in the same organisation, where one had good leadership that allowed people to address mistakes directly and question one another, and the other had a command-and-control style with 'an individualistic dynamic and a blame culture'."

The CQC defines a closed culture as 'a poor culture that can lead to harm, including human rights breaches such as abuse.' In these services, people are more likely to be at risk of deliberate or unintentional harm. Unfortunately, there have been many national examples where people have experienced and suffered harm

because of a closed culture, including Whorlton Hall within our own health and care system in the North East and North Cumbria. Closed cultures can happen anywhere. We have seen this highlighted through CQC inspections, independent investigations, and even employment tribunal decisions, which have identified very different cultures within some services and departments. We will strive to identify, reduce, and eliminate the risk of closed cultures within our system, by continuing to improve quality assurance of services and increase staff knowledge and skills to identify when a closed culture may occur.

The Reading the Signals report (2022) into East Kent University Hospitals NHS Foundation Trust's maternity and neonatal services identified four areas for action, three of which included key aspects of culture that support positive safety cultures. These four actions are that the NHS could be much better at:

- Identifying poorly performing units.
- Giving care with compassion and kindness.
- Teamworking with a common purpose.
- Responding to challenge with honesty.

The report highlights that none of these are easy or necessarily straightforward, because longstanding issues become deeply embedded and difficult to change. But unless these difficult areas are tackled, we will surely see the same failures arise somewhere else, sooner rather than later, and the report must be a catalyst for tackling these deep-rooted problems. As part of the culture and climate across our ICS, we are committed to tackling these issues, so we can "read the signals" and identify areas that we need to focus on, that enable us to continually develop and improve the quality of services.

Several key themes have been identified in relation to health inequalities and patient safety. The themes include communication between clinicians, patients and carers; patient involvement in their own safety; accessibility of healthcare; cultural competency of the workforce and system; transitions of care; geographical variation and data quality.

Therefore, across the ICS we will foster a proactive and positive culture of safety and a climate that is based on openness and honesty, in which concerns about safety are listened to, safety events are investigated, and lessons are learned to continually identify improvement and embed good practices.

Our call to action

To do this, safety and high quality care needs to be a priority for all regardless of role, seniority or organisation. Everyone needs to play their part and collaborate across the system for improvement.

- We will continue to foster relationships built on trust and understanding of our roles, responsibilities, and accountabilities, where collaboration rather than competition is integral to our success, and we will have a shared endeavour that drives improvements and system priorities collectively.
- To help us to achieve this, we have defined values and behaviours we will adopt, with some enabling factors and enacting behaviours for the system, organisations, services, and individual members of staff; these will be key in creating the culture and climate we aspire to.

This is our call to action

We will do this by adopting the values and behaviours of the following principles:

Professional curiosity
We will adopt a culture of professional curiosity within the system from staff in frontline services through to members of the board. This will enable staff to have a holistic view and understanding of what is happening, use this information to fully assess potential risks, and maintain an objective, professional and supportive approach to improvement.

Just culture
In line with the principles of a 'just culture', we want to create a culture of fairness, openness and learning within our system. This will make colleagues feel confident to speak up when things go wrong, rather than fearing blame and allows valuable lessons to be learnt, which helps to prevent the same mistakes being repeated.

Freedom to Speak Up
The Freedom to Speak Up initiative was started as a means to create an environment that enables and empowers staff to raise concerns they might have or observe in their area of work, and to notify the relevant body or authority with the knowledge that action will be taken as a result. We will continue to encourage ad support people to speak up about concerns without fear of reprisal, so that organisations and the system can keep improving services for all patients and the working environment for staff.

NHS People Promise
We will act on the NHS People Promise so that we embed a culture across the system that is compassionate, positive, and inclusive. The promises are:

- We are compassionate and inclusive.
- We are recognised and rewarded.
- We each have a voice that counts.
- We are safe and healthy.
- We are always learning.
- We work flexibly.
- We are a team.

Equality, diversity, and inclusion
We value diversity in our communities and workforce; we will work towards an inclusive and fair culture by improving equality and equity for people who use services and for those who work within our system. Within our system culture we will strive to improve equality, diversity, and inclusion, and to enhance the sense of belonging for our people and staff to improve their experience. Everyone should have access to high quality care, and we are committed to identifying and reducing variation and health inequalities.

Personalised care
We will aim to move from asking people 'What's the matter with you?' to 'What matters to you?' so that we understand and respond to people's healthcare needs and give them informed choices when we are delivering care.

Creating the culture and climate

These are the factors and behaviours that will help us to build a safer culture and drive positive health outcomes for our people.

System/ organisations

- Leadership commitment
- Prioritisation of patient safety
- Policies and resources for safety
- Learning culture and communities
- Working together with collaborative decision making
- Aligned vision and values and shared endeavour
- Shared commitment to system-based performance and priorities
- Leadership at all levels

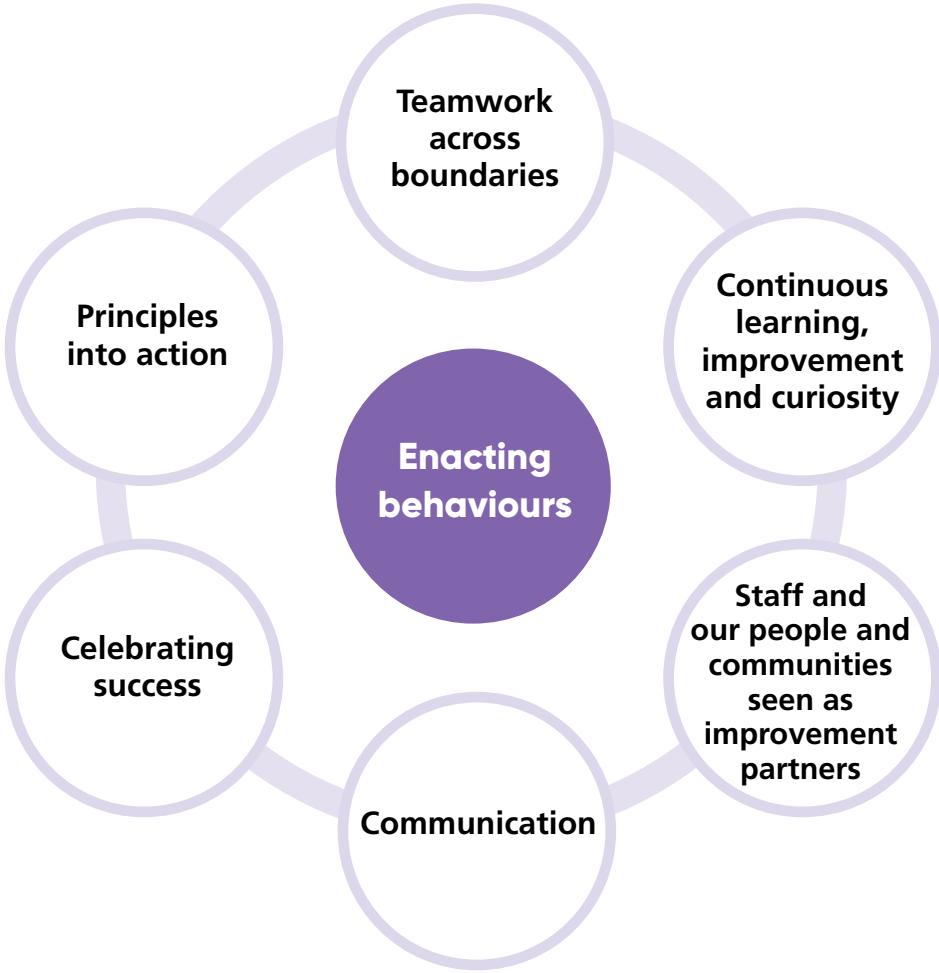
Services/teams

- Teamwork and cohesion
- Psychological safety
- Empowered to deliver safe high quality care
- Engaged and motivated staff
- Clearly defined and embedded systems to keep people safe
- Risks to quality and safety are assessed, monitored and managed on a day to day basis

Individuals

- Safety knowledge, expertise and skills
- Individual commitment and prioritisation of safety
- Empowered to drive quality improvements
- Understand their role in delivering safe high quality care

Enabling factors



Patient safety

What we mean by patient safety

Patients are safe. Patient safety is important for everyone involved in health and care. Leaders make sure staff can be honest when things go wrong. And staff work together to make care safer.

Patient safety

- We all make safety important and will improve safety
- We work across organisations so our systems promote safe and high quality care.
- We promote honesty and learning to improve safety.
- We deliver care in a way that lessens the risk of things going wrong.
- We celebrate outstanding health and care.
- We learn when things go well and when things have not gone well.
- We find risks then put things right, learn and improve.
- We think about how inequality impacts on patient safety. This reduces the risk of harm.

What this means to our people and communities

- I feel safe and am supported to get help to learn about and manage any risks.
- If something goes wrong, I get support and will receive an apology.
- When things don't go well, services learn and improve.
- I am cared for by staff who have the skills and experience to best support me.
- I know staff understand my needs and they care for me in a way that reduces any risks.
- I know who and where to contact if I feel worried or I don't feel safe.

What this means for the system

- We have a culture of safety and learning. Staff know safety is important and can raise concerns. Concerns are looked in to and learning takes place.
- We share learning across different organisations.
- We can show improvements in health and care across different organisations that improves people's experiences of care.
- There is a reduction in variation and health inequalities.
- Care meets personal needs, improving results and fairness. It reduces the risk of harm that can be avoided.
- We have encompassed human factors to underpin our approach to patient safety and quality improvement.
- The approach to the patient safety incident response framework across the system has been embedded.
- We have established communities of practice – groups who work together to make improvements.
- Staff know their role in safe care and quality improvements.

Clinical effectiveness

What we mean by clinical effectiveness

Treatments and care are proven to work. Our organisations work together to keep improving results for patients. This includes gathering information on the medical treatments and care we provide, so we know what gets the best results.

Clinical effectiveness

- We give the right care, at the right time, in the right place.
- We share what works well and learn from others.
- We analyse data and information to make sure quality of care is high.
- We measure quality and publish what we measure. This informs decisions.
- We set clear standards for high quality care, based on what matters to people and our communities.
- We ensure there's co-ordination of services across the system, that bring together services across different organisations. We think about need, preference and difference when we do this.
- We think about the things that affect health and equality which may lead to poorer outcomes and premature deaths. We respond together to address this.

What this means to our people and communities

- I have care and support that is co-ordinated, and everyone works well together and with me.
- I am empowered to get the care, support and treatment that I need.
- I know my care is effective and is a high standard.
- Different services work well together to ensure I receive high quality care.
- When I move between services, it feels well planned and all the arrangements are in place.

What this means for the system

- We have systems that help us to use data and information when making decisions.
- Our clinical conditions strategic plans are improving outcomes and equity.
- We work in new ways based on research and evidence. This supports high quality care.
- We have a quality improvement methodology to support our improvement work across the system.
- We design services to meet diverse needs. We promote fair access, excellent experience and better outcomes for all. This reduces disadvantage, and the risk of harm.
- Staff keep up to date with best practice.
- Staff deliver care that makes patient health and experience the best it can be.

Clinical and multi-professional leadership

What we mean by clinical and multi-professional leadership

Doctors, nurses and other staff lead change: Health staff can learn and keep getting better. Quality, learning and improvement is part of leadership. We support staff to design services with patients.

Clinical and multi-professional leadership

- We have accountable and compassionate leaders with shared vision, values, and learning.
- We have leaders who are inclusive and know the context in which we deliver services and embody the culture and values of the system.
- Clinical and care professionals who have contact with patients are involved in decisions at all levels.
- We recruit leaders in an open, fair and inclusive way.
- We recruit leaders who can work well with other organisations and across the system.

What this means to our people and communities

- When I receive care, leaders and staff support services to meet my needs.
- I will be involved in designing services.
- My feedback is heard and valued by leaders.
- Leaders and staff spot poor care quickly, and make improvements.
- Staff and leaders have the right skills and experience to make decisions about services.

What this means for the system

- We have high-quality leadership throughout organisations and the system working to deliver heath and care.
- If any examples of poor culture arise, leaders will quickly resolve this
- Our leaders are skilled and can contribute effectively to quality improvement.
- We plan for leadership changes. We recruit effectively and inclusively.
- We have leadership strategies and development opportunities across organisations
- Leadership is central; all staff understand their role in delivering high quality care.

Positive experiences

What we mean by positive experiences

We know what matters to people, and they can make informed decisions. Services are delivered with compassion and respect.

Positive experiences

- We make it easy for people to feedback or complain about care and treatment.
- We involve people in decisions about their care.
- We listen to people who are most likely to have poorer experiences, outcomes or results.
- We deliver services with compassion, respect. We empower people to make informed choices.
- We work with people who have 'lived experience' to design services.
- We tell people what we have changed because of their feedback.

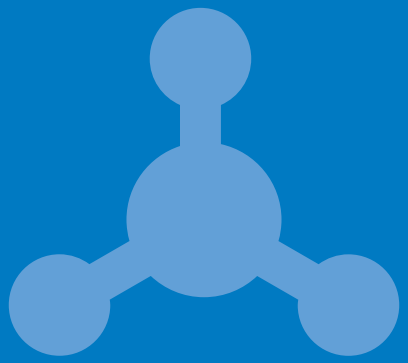
What this means to our people and communities

- I am seen as an individual and staff help me to live as I want to.
- My personal needs are understood and met and these are reflected in my care, treatment and support, and takes account of my personal, language, cultural, social and religious requirements. This includes:
  - My cultural and religious needs
  - My disability needs
  - My social needs
- Staff help me to manage my health in a way that works for me.
- I am involved in decisions about my care.
- Staff listen to me.
- Staff help me to speak up and give feedback in a way that works for me.
- My feedback makes a difference.

What this means for the system

- People's views help improve the quality of services and are part of our quality improvement work.
- Feedback helps us learn where there are risks in services. It also helps us check services are high quality.
- Feedback can help spot early signs of poor care and a closed culture.
- We know about the health and care needs of people and communities. This means care is joined-up, flexible and supports choice.
- Public involvement strategies inform all of our work.
- Services are shaped around what matters to people.
- People are empowered to make decisions about their care and staff know their role in this.
- Our staff understand their role in supporting people to make informed choices about their care.

6. Working together to deliver quality – how we will do it



Working together

As an ICB and commissioner:

- Set clear quality standards and expected outcomes when commissioning as part of quality and performance management.
- Developed the system as the 'best at getting better' with established communities of practice.
- Have clear governance frameworks for quality.
- Quality assurance gives a clear and accurate picture of safety, and there are steady improvements in safety over time.
- Develop a positive safety culture that is embedded at all levels of the system.
- Work together across the system to ensure seamless pathways between services that focus on delivery of high-quality care.
- To co-produce with communities to shape services to meet their needs.
- Share learning, best practice, and innovations across the system to influence and improve the quality of services.
- We have consistency in approaches which leads to more standardised practices in services.

For people and communities:

- People in our communities know what good care looks like, what they have a right to expect, and what to do when their experience doesn't meet expectations.
- People are partners in their care and are supported in making decisions about the care they want to receive.
- People have care that is personalised, and they are treated with dignity and respect.
- People's voices are heard, listened to, and understood and feedback is used to drive improvements in quality.
- People are included in reviews and contribute to improvements in care.

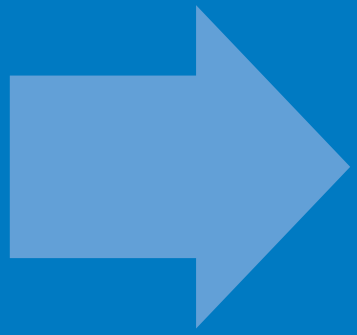
For all health and care providers:

- Experience a coherent system of quality assurance and performance management.
- Are accountable for the quality of care they provide, and driving quality improvements which translates into improved health outcomes.
- Care is co-ordinated across services, organisations and the system and they work collaboratively to meet people's needs.
- Support the system to continually improve and maintain quality and safety standards.
- Work as system partners and understand their role in improving health outcomes, reducing variation and health inequalities.

For all staff:

- Staff are seen as partners in delivering safe high-quality care,
- Staff feel safe and confident to speak up without fear of retribution.
- Staff are supported to learn and make improvements to care at every level of the system.
- Staff are engaged and motivated to develop and drive improvement plans.
- Staff are supported to learn and develop to embed quality and safety practices in their everyday work.

7. Foundations and next steps



Foundations and next steps

In the next 12 months we plan to further build on the first steps we have already taken and focus on developing and implementing our next steps for each strategic theme.

Culture and climate

Foundations

- Established Freedom to Speak Up (FTSU) processes across the ICB.
- ICB assessment of FTSU processes in NHS trusts
- Adoption and implementation of NHS People promise/Just culture.
- Development of our People and Culture strategy
- Quality assurance tools developed for some services with specific prompts around closed cultures.
- Recognise the need for clear values and behaviours both within the ICB and across the system
- Closed cultures highlighted as a strategic quality priority.
- Intelligence sharing between stakeholders.

Next steps

- Clear set of values and behaviours for the ICB as an organisation and the wider system.
- Implementation of the our People and Culture Strategy
- People promise exemplers in the region.
- Review of tools for both commissioning and quality assurance to ensure they include key culture prompts.
- Staff at all levels, regardless of role understand their roles and responsibilities.
- Learning packages about culture/closed cultures for all staff in the system.
- Staff at all levels understand the inherent risk factors and warning signs for a closed culture.
- Develop system-wide plan to tackle closed cultures.

Patient safety

Foundations

- Concept developed for our Patient Safety Centre.
- Development and implementation of the ICB Patient Safety Incident Review Framework (PSIRF) policy and approach. This includes:
  - » Support to organisations and sign off PSIRP plans.
  - » Training and development including raising awareness, patient safety specialist training and patient safety partner identified and agreed.
  - » System wide 'never event' deep dive.
  - » System approach identified to the implementation of Martha's rule.
  - » Data and intelligence monitoring information available for the ICB.
  - » Patient safety improvement plans in trusts developed, identified by people's experience, data and intelligence.

Next steps

- Launch of our Patient Safety Centre in October 2024; the centre will be our focal point to drive patient safety improvements.
- Develop the ICB and system-wide Safety Management System (SMS) aligned to our Quality Management System (QMS).
- Specific learning and improvement sessions across the system.
- Roll out of PSIRF training for all staff, existing patient safety specialists to complete training, approval of the model for patient safety specialists, and learning support specialists.
- Development and embedding communities of practice.
- Further enhancements to data and intelligence monitoring to incorporate people's experiences.
- Enhance routine reporting requirements for all commissioned services as part of contracts.

Clinical effectiveness

Foundations

- Clinical Conditions Strategic Plan for adults and children developed.
- Our Healthy and Fairer Programme including: prevention, health inequalities and broader social and economic determinants.
- Part of CQC stakeholder forum for the development of the health inequalities self assessment.
- Women's health conference and investment in three new hubs focusing on women's health.
- Launched a health profile and developed a needs assessment which provides an overview of inequalities in health outcomes and risk factors for women.
- Monitoring of mortality themes and trends.
- Quality improvement methodology approach being developed.

Next steps

- Launch of our Clinical Conditions Strategic Plan with monitoring of improvements.
- Healthier and Fairer Programmes including tobacco, CORE20PLUS5, and poverty proofing.
- Part of CQC's health inequalities stakeholder group and the development of the self assessment tool.
- Clinical effectiveness subcommittee in place with clearly identified plans for clinical effectiveness, evidenced based practice and continuous service improvement.
- Medicine optimisations and strategic plan developed.
- Quality improvement methodology developed and used as part of our quality improvement work.

Clinical and multi-professional leadership

Foundations

- Clinical and Multi-Professional Leadership Framework developed for the region.
- People and Culture Strategy to develop future leaders and create opportunities to learn together.
- System Leadership Group established across the region.
- Senior leaders meetings/forums within the ICB.
- Boost, our learning community, offers leadership development to support staff to be effective conveyors of system change.
- Allied Health Professional (AHP) Council established and operational across the region.
- Chief Nurse and Medical Director meetings established to share and learn across the region.

Next steps

- Wider engagement to take place on the Clinical and Multi-Professional Leadership Framework.
- Self assessment/gap analysis to be undertaken.
- Decision making map to be developed - to show how clinical leaders are involved in every level of decision making.
- Learning and development needs to be reviewed across the region including generic and profession specific.
- System leadership development at every level.
- AHP development to support clinical and professional learning, skills and experience.

Positive experiences

Foundations

Our People and Communities Involvement and Engagement Framework developed to provide a strategic approach and consistent standard reflecting our principles of involvement.

- Involvement toolkit developed to support staff to involve people in their work.
- Healthwatch programme of activities to support the ICB embed engagement and involvement in all that we do.
- ICB complaints management and ongoing monitoring of patient experience surveys including CQC.
- Patient stories at ICB's Quality and Safety Committee.
- Involvement dashboard developed to show the breadth of involvement work across the region.

Next steps

- Our People and Communities Involvement and Engagement Framework to be refreshed with support from Healthwatch.
- Continue to gather and learn from people's experiences to support continuous improvement of services.
- Quality of complaints to be part of quality assurance framework for commissioned services. Assessment tool developed to assess the quality of provider complaints systems.
- In response to patient feedback, which identified a need for further work to support those waiting for a child and adolescent mental health services (CAMHS) appointment, development of a practical waiting well approach to support people waiting for CAMHS.

Quality Management System (QMS)

Foundations

- Quality assurance and monitoring; developing a consistent approach across the ICB and pilot tools developed.
- Standardised tool developed to support assessment of complex care caseload and responsive safety assessment tool.
- System Equality and Quality Impact Assessment Policy developed including equality and health inequalities- pilot of tool being undertaken.
- Internal audit in relation to governance of commissioned services.
- Independent investigation reports reviewed, and thematic analysis completed of ICB recommendations.
- Some policies identified as requiring updating - tools developed and process established to review all ICB policies.
- Incidents and risk registers - gaps in assurance identified, plans developed to address this.
- Quality governance meeting proposal developed - engagement started.

Next steps

- Quality Management System (QMS) developed to provide quality assurance and monitoring of commissioned services; supporting a consistent approach across the region.
- QMS and Safety Management System (SMS) developed and working in conjunction with each other, to support identification and management of quality and safety concerns.
- Independent reviews - key themes identified and plan to be developed to identify actions/ action owners.
- Overarching improvement plan to improve quality governance arrangements and how this correlates with corporate governance.
- NHSE ICS quality functions: Self-assessment tool developed to assess our compliance with the quality functions, this needs to be undertaken.
- Self-assessment against CQC standards: Tool to be developed for key ICS quality statements and also CQC well-led framework for NHS trusts.

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September 2024